Year 2
Direct Support Professional Training

Resource Guide

Session #3
Person-Centered Planning and Services

Department of Education
and the
Regional Occupational Centers and Programs
in partnership with the
Department of Developmental Services

2000

List of Class Sessions

Session	Topic	Time
1	Introduction and Supporting Choice: Identifying Preferences	3 hours
2	Person-Centered Planning and Services	3 hours
3	**Person-Centered Planning and Services**	**3 hours**
4	Communication, Problem-Solving and Conflict Resolution	3 hours
5	Positive Behavior Support: Understanding Behavior as Communication	3 hours
6	Positive Behavior Support: Adapting Support Strategies to Ensure Success	3 hours
7	Teaching Strategies: Personalizing Skill Development	3 hours
8	Teaching Strategies: Ensuring Meaningful Life Skills	3 hours
9	Supporting Quality Life Transitions	3 hours
10	Wellness: Medication	3 hours
11	Wellness: Promoting Good Health	3 hours
12	Assessment	2 hours
	Total Class Sessions	**12**
	Total Class Time	**35 hours**

Key Words

In this session, the key words are:

- Regional Center Service Coordinator
- Person-Centered Planning Team
- Person-Centered Individual Program Plan
- Goal
- Services and Supports
- Review Dates
- Recording Progress

Information Brief

Regional Centers and Service Coordinators

In California, many services for people with developmental disabilities are coordinated through a network of twenty-one, non-profit regional centers. If a person is eligible, regional centers provide planning and service coordination.

Service coordinators (sometimes called case managers or social workers) help individuals and families with the information they need to use community services and supports. He or she is also an important member of the person-centered planning team. The service coordinator must be present on the team when the IPP is developed and any time it is changes.

In addition to helping develop the IPP, a typical day for a service coordinator can include: writing up an annual progress report; arranging for services mentioned in the IPP; taking care of urgent issues (for example, someone needs a new place to live); meeting with service providers (day programs, schools, work programs); attending staff meeting returning phone calls; and completing paperwork.

Another major role of the regional center is the purchase of services. If included in the *IPP*, a regional center may purchase a service from an approved service provider. Here are some of the *typical* services coordinated through a regional center:

- *Advocacy* – assisting individuals to get needed services from community and government agencies;

Your Notes

- *Assessment* – gathering information about individual service needs and supports;
- *Positive Behavior Support* – classes and individual consultation around positive behavior supports;
- *Early intervention programs* – for children not yet in public school; includes neighborhood preschools, and infant development programs;
- *Independent/Supported living* – services and supports for adults who live in their own homes;
- *Medical* – identifying and accessing needed health services;
- *Residential* – licensed or certified residential options including long-term health care facilities, foster family homes, community care homes, and family home agencies;
- *Respite Care* – support for the family in order to provide a break from care-giving responsibilities;
- *Social/Recreational* – locating a social/ recreational activity;
- *Therapy and Counseling* – referral to various therapists and public or private mental health agencies; and
- *Vocational* – work-related services and supports (for example, job placement, coaching, sheltered work, and day services), some are funded by regional centers, others by the Department of Rehabilitation.

Your Notes

Information Brief

A Brief History of the Individual Plan

In the early 1970's, there were a number of court cases about the answer to the question:

> *What are the rights of people with developmental disabilities?*

In general, the courts answered that people with developmental disabilities have the same rights as everyone else. While this helped, it created a new set of questions. Since everyone is different, the next question became *what is the best way to make sure that individuals with developmental disabilities get the services and supports that they need?* In the mid 1970's, many federal and state laws were passed to help clear up this issue.

All of these laws state that to get the right support, a plan of service must be written that looks at each person's individual needs. This became known as the *Individual Plan.* As the years have passed, lots of **I** (fill in the blank) **P's** have been created Here are just a few:

Plan	**Agency**
Individual Program Plan	*Regional Center*
Individual Education Plan	*School*
Individual Family Support Plan	*School and Regional Center*
Individual Transition Plan	*School*
Individual Habilitation Plan	*Department of Rehabilitation*
Individual Work Related Plan	*Department of Rehabilitation*

Your Notes

While there are some differences in all of individual plans (some are for students, some are concerned with work only), things that all of them have in common are that they:

- are written down;
- are developed by the individual and others involved with the person's life (a team approach);
- outline the things that a person can do well (strengths, preferences, capabilities) and their plans for the future (life goals);
- outline the things that get in the way (barriers) and things that a person needs help with (support needs);
- list the steps are needed for a person to learn, live or work more independently (goals, objectives, services and supports);
- list who will help with the services and when (responsibilities);
- list ways to tell if the services help (progress towards goals); and
- state when the plan should be looked at again (review date).

Your Notes

Information Brief

The Person-Centered Individual Program Plan

Introduction

While Regional Center Individual Program Plans may look different, there are some things that California law (Lanterman Act, Title 17) says must be the same. This article is about those things which all Regional Centers must do when working on the IPP.

IPPs are Person-Centered

All regional centers are required to use a person-centered approach when planning for the Individual Program Plan. An IPP describes the needs, preferences and choices of the individual and family. It is developed through a process of figuring out individualized needs and preferences. The IPP changes as individual needs and preferences change.

Individual Choice

Individuals have a right to make choices and have them written into the IPP. Those choices include, where and with whom to live (at home with parents, with a friend, in a group), the way people spend their time each day and with whom (day program, work, volunteer), choice about things to do for fun (movies, camping, out to eat), and plans for the future (saving for a vacation, living with a friend). To help individuals

Your Notes

and families make good choices, information about different kinds of services must be presented in a way that's easy to understand.

The Planning Team

A planning team is a group of people who work together to support the choices and preferences of one of the individual. The team meets to share what they have learned about the life patterns, interests, and preferences of an individual from the person-centered planning process. The person-centered planning process provides the team with a picture of the strengths and abilities of the individual, as well as the challenges that he or she faces.

The planning team is made up of the individual and the Regional Center service coordinator. Individuals can invite others to participate on the planning team like family members, friends, neighbors, advocates and d*irect support professionals.* If an individual has a legal representative or a guardian or conservator, they must also be on the team. To make sure that individuals are able to actively participate, it may also be necessary to include a translator or interpreter on the team.

Your Notes

Assessment

When the planning team shares what they know about the life patterns, interests, and preferences, of an individual, they are completing an assessment. When the team decides that more information is needed, a specialist (for example, speech therapist, psychologist) may be asked to complete an assessment as well.

The IPP Meeting

The Regional Center service coordinator helps schedule the meeting of the planning team. The location, time, date, and length of the IPP team meeting should meet the needs and preferences of the individual and family. The idea is to make the meeting as comfortable as possible for everyone involved. For example, some individuals may need a series of shorter meetings and others may ask for phone conferences. Some times, individuals and families may ask for an informal meeting place like as a restaurant, barbecue, or picnic.

When the team meets to develop the person-centered IPP, this is called a planning conference. One of the purposes of the meeting is to bring all the members of the team together for a face-to-face discussion. During the meeting, there are several important roles for team members:

Team Leader. This can be anyone on the team who wants to help keep the meeting going. It is quite often the regional center service coordinator.

Your Notes

Team Recorder. Someone who will takes notes during the meeting.

Team Members. Everyone who comes to support the person working on the IPP.

The information discussed at the planning conference and the decisions and choices that are made become the person-centered Individual Program Plan.

The Major Parts of the IPP

The basic parts of the person-centered Individual Program Plan are:

- **Goals**
- **Objectives**
- **Services and Supports**
- **Review Date**

Goals are the things that people want to do or learn. They are the choices that people make about where to live, what to do during the day, who to spend time with, what to do for fun and hopes and dreams. Here are some examples:

Learn how to ride the bus.

Join a church.

Get a job.

Live in my own apartment.

Learn how to ride a bike.

Save money for a vacation.

Your Notes

Objectives are the steps needed to move toward a goal. An objective needs to have a date written into it so the individual and his or her team will know if the goal is getting closer.

If someone's goal is:
Joan wants to save money for her vacation trip.

Objectives (or first steps) might be:
By the end of January, Joan will open a savings account.

By the end of June, Joan will have saved $50 towards her vacation trip.

If someone's goal is:
Travis wants to join a church.

Objectives (or first steps) might be:
By the end of June, Travis will have a chance to visit four churches.

By the end of July, Travis will choose a church to join.

There are many kinds of ***services and supports*** that can be listed in an IPP, depending on the support needs of the individual. Some of those services and supports are:

- **a place to live** (for example, emergency housing, foster family, group home, supported living, help in finding a place, homemaker services);

- **a place to learn or work** (for example, education, day program, workshop, supported employment, competitive employment);

Your Notes

- **getting around** (for example, transportation, travel training, recreation, adaptive equipment); and,

- **staying healthy** (for example, counseling, mental health services, medical or dental services.

The law says that regional centers must first try to use regular community services before it can purchase service and supports from vendorized providers (for example, residential or day services).

The plan should also have written into it some times (review dates) when everyone on the team will get together and look at how things are going. This is a time to find out if the individual (and their family if someone is under 18) is happy with their current services and supports and if there is progress towards individual goals. If things aren't going well on one of the goals or if someone is unhappy with their services and supports, then it may be time to change the plan and the services and supports.

Your Notes

A Reminder

When you're working on a person-centered IPP, remember that it's about 4 things:

1. getting to know someone;
2. finding out about individual choices, preferences and life goals;
3. making a team plan to support those choices; and
4. figuring out what services and supports are needed to reach those goals.

Information Brief

Some Tips on Successful Writing

It's important to know some basic writing tips as a *Direct Support Professional.* You will probably be writing something almost every day. In progress notes, you will be writing about: (1) progress on individual goals; or (2) things that are and are not going well for an individual; or (3) goods ways that you have found to work with an individual. You might also need to write up a special incident or information on a community activity log. Whether you are writing a progress note, filling out a community activity log, or a special incident report, everyone can improve on his or her writing skills. Here are some general tips:

1. **Know who are you writing to**
   Other staff? A service coordinator at the regional center? Are you writing to a family of someone you support? Think of what you write as though you're having a face-to-face conversation with the person. If you can write it that way, it should be easy to understand.

2. **Know what you're writing about**
   For example, if you're writing about a special incident, make sure you know everything that happened before you write it down.

3. **Get to the point**
   Start off your first sentence with the point you want to make. Use short and familiar words instead of long or unusual ones. This helps keep your writing clear and to the point.

Your Notes

4. **Be respectful and courteous**
   You may be feeling strong emotions when writing something, but keep it positive. Remember that you are producing a written record for others to see.

5. **Use a spell and grammar checker if you use a computer**
   If you are using a computer and a word processor application, use the spell check and the grammar check if there is one. A reader will lose interest in what you have to say if there are a lot spelling, grammar, or punctuation errors.

6. **Use the active voice**
   Unless you're writing something like a legal document, it's best to use the active voice in your writing. Here is an example:

   Active Voice
   I visited with the family at their home.

   Passive Voice
   The visit took place at the family home.

   As you can see, an active voice sounds more conversational.

7. **Stick to the facts**
   Unless you are asked to, write what you see and observe and not what you feel or think.

Your Notes

Review from Year 1

A Guide to Talking and Writing about People with Disabilities - People First*

In talking and writing about people with disabilities, remember *it's people first, the disability comes second.* The subtle difference between calling Joe "a person with mental retardation" rather than a mentally retarded person is one which acknowledges Joe as a person first.

AVOID:	*USE:*
victim	**individual with a developmental disability**
invalid	**individual with a seizure disorder**
crippled	**individual with cognitive disabilities**
afflicted with	**a person who is non-ambulatory**
suffers from	**individual with Down Syndrome**
DDs	**individual**
TMRs	**person**
EMRs	**participant**
confined to a wheelchair	**worker**
mongoloid	**student**
the retarded	
the handicapped	
mentally deficient	
patient	

* Adapted from **Put in a Good Word for Me**, North Los Angeles County Regional Center.

Key Word Dictionary
Person-Centered Planning Session #3

Goal
Goals are the things that people want to do in the next few years. They are the choices that people make about where to live, what to do during the day, who to spend time with, what to do for fun and hopes and dreams

Objective
Objectives are the steps needed to move toward a goal. An objective needs to have a date written into it so the team will know if the goal is getting closer.

Person-Centered Individual Program Plan
The person-centered planning process helps the team figure out the preferences, needs and choices of an individual. Once that process is completed, the team talks about the kinds of services needed to support the person now and in the future and the person-centered Individual Program Plan is developed. The plan includes: (1) kinds of services and supports the individual needs, (2) who will provide each service and support, and (3) how these services and supports will assist the individual to have opportunities to experience what is important to him or her and to get moving towards his/her goals for the future.

Recording Progress
As a DSP, you will be asked to provide information to the team about individual progress on goals and objectives. This is usually done by writing progress notes on each individual. In progress notes, you will be writing about: (1) progress on individual goals; or (2) things that are and are not going well for an individual; or (3) goods ways that you have found to work with an individual.

Regional Center
In California, many services for people with (or 'at risk') of a developmental disability are coordinated through a network of twenty-one, non-profit Regional Centers established by the Lanterman Act. If a person is eligible, Regional Centers provide planning and related services, including service coordination.

Regional Center Service Coordinator
Service coordinators (sometimes called case managers or social workers) help individuals and families with the information they need to use community services and supports. In addition to helping develop the Individual Program Plan (IPP), service coordinators help arrange for the services and supports mentioned in the IPP.

Review Dates

The IPP should have written into it some times or review dates, when everyone on the team will get together and look at how things are going. This is a time to find out if the individual (and their family if someone is under 18) is happy with their current services and supports and if there is progress towards individual goals. If things aren't going well on one of the goals or if someone is unhappy with their services and supports, then it may be time to change the plan and the services and supports.

Services and Supports

There are many kinds of ***services and supports*** that can be listed in an Individual Program Plan, depending on the support needs of the individual. Some of those services and supports are: (1) **a place to live** (for example, emergency housing, foster family, group home, supported living, help in finding a place, homemaker services); (2) **a place to learn or work** (for example, education, day program, workshop, supported employment, competitive employment); (3) **getting around** (for example, transportation, travel training, recreation, adaptive equipment); and, (4) **staying healthy** (for example, counseling, mental health services, medical or dental services.

If You Want to Read More About
Person-Centered Planning and Services

Learn the Basics, Learn the Process, Apply What You Learn: Service Coordination Orientation and Training Curriculum
by the Southern California Training and Information Group (1999)

A three part guide for regional center service coordinators on the many aspects of that work from problem-solving to purchase-of-service.

More Than a Meeting: A Pocket Guide to the Person-Centered Individual Program Plan
Prepared by the California Department of Developmental Services (1994)

A guide for individuals and families on the person-centered planning process and the Individual Program Plan.

Worksheets and Activities

Activity:
Getting Ready for a Planning Team Meeting

After you have seen the video about Joe, divide up into small groups and choose someone to be a recorder for this activity. Your job is to help Joe think about things he would like to talk about at his next planning team meeting. The team will use this information to help Joe write his person-centered Individual Program Plan. Since person-centered planning always includes the person, someone in your group needs to play Joe. You can ask Joe questions about things he might to talk about at his next planning meeting. As a group, write up two of your ideas. Here's a hint, think about: (1) the kinds of things Joe likes to do in the community; and (2) some opportunities for learning new things to support his health.

Possible ideas for Joe to talk about at his next team planning meeting:

#1.

#2.

Activity:
Getting Ready for a Planning Team Meeting

After you have seen the video about Bruce, divide up into small groups and choose someone to be a recorder for this activity. Your job is to help Bruce think about things he would like to talk about at his next planning team meeting. The team will use this information to help Bruce write his person-centered Individual Program Plan. Since person-centered planning always includes the person, someone in your group needs to play Bruce. You can ask Bruce questions about things he might to talk about at his next planning meeting. As a group, write up one of your ideas. Think about the kinds of things Bruce likes to do in the community and some ways he could expand those activities.

A possible idea for Bruce to talk about at his next team planning meeting:

-

Activity:
Recording What You Observe

Your job is to come up with a first step that a DSP might observe for each of the goals below. These would be things that you could write down in a daily log or a staff note. This information will be important for the next team planning meeting when they talk about progress on IPP goals.

Goal: Learn how to drive a car.
A first step toward the goal that a DSP could observe and record:

Goal: Learn more about diet and nutrition.
A first step toward the goal that a DSP could observe and record:

Join a health club.
A first step toward the goal that a DSP could observe and record:

Activity:
Looking at Individual Progress

As a DSP, you will be asked to provide information to the team about individual progress on goals and objectives. On the following page is an example of an individual progress record from a community care home. Vernon has decided that he wants to do more for himself and that shaving would be a good start. As you can see, the objective for shaving is broken down into steps (task analysis) and information about progress has been collected on a regular basis. Your job as a team is to look at the progress record and to answer the questions below:

1. What has happened with Vernon's **level of independence** over time?

2. What steps in the process of shaving are difficult for Vernon?

3. What creative things could you do to help Vernon be more successful on those steps?

4. Should this objective be continued? Why or why not?

Teaching Plan and Individual Progress Record

Name: Vernon Mayberry_____ Goal: Vernon wants to do more for himself

Objective: Learn to shave himself by June 30th

"**+**" = independent "**O**" = Needs a prompt

Task Analysis:

	5/1	**5/2**	**5/3**	**5/4**	**5/5**	**5/6**	**5/7**	**5/8**	**5/9**	**5/10**
1. Gets shaver	0	0	0	0	0	0	0	0	0	0
2. Plugs in shaver	0	0	0	0	0	+	+	+	+	+
3. Turns on shaver	+	+	+	+	+	+	+	+	+	+
4. Shaves faces	+	0	0	0	+	+	+	+	+	+
5. Feels for unshaven beard	0	0	0	0	0	0	0	0	0	0
6. Turns off shaver	0	0	0	0	+	+	+	+	+	+
7. Puts shaver away	0	0	0	+	+	+	+	+	+	+
8. _____										
9. _____										
10. _____										
11. _____										
12. _____										
13. _____										
14. _____										

Excerpts from Fred's Person-Centered INDIVIDUAL PROGRAM PLAN

Things We Know About Fred at Home

Fred participates in a variety of household chores (for example, helps cook dinner, set the table, make his bed, do the laundry). While he can complete many of these chores without many prompts, he needs to be in the company of support staff at all times as he will exit the house without warning. Fred need some help with personal care, washing his hair, putting on lotion after showering, tooth brushing, but it's very important that he do as much as he can on his own.

Things We Know About Fred's Health

He currently takes seizure medication on a daily basis. He will spit out his medication if not supervised. He is in basic good health, but needs supervision in what he eats in order to prevent severe constipation.

Things We Know About Fred's Social Life

Fred likes to be on the go every day of the week. He loves to hop in the van and go someplace after work and several times on the weekend. He particularly likes to help shop for groceries, hike, take short walks, swim, eat out in restaurants. He needs support when ordering food, making purchases and staying with the group. He sometimes takes off clothes in public, takes food he likes from others in a restaurant, and urinates in public.

Activity:
Fred's IPP and
Your Responsibilities in Supporting Him

As a team, look at and talk about Fred's person-centered IPP so that you can answer the following questions.

What kinds of things would Fred like to help you do around the house?

What do you need to know about Fred when he is taking his medication?

If you don't watch what Fred eats, what can happen?

What kinds of community activities does Fred like?

If you were going to take Fred to the mall, what concerns might you have?

What kinds of support does Fred need from you during community activities?

Activity:
Write a Team Note About Fred

After you have divided up into teams, one of you should be a recorder for this activity. You can look at the excerpts from Fred's Individual Program Plan to complete this activity. It will remind you of the things that Fred likes to do in the community. Write a weekly note that sums up how you have worked with Fred on this goal. Use your creativity and knowledge about Fred to make it sound like it really happened. Don't forget to use the successful writing tips to make it respectful, clear and easy-to-understand.

Weekly Team Note

Name of Individual: Fred Jones **Dates:** 10/12/00 -10/18/00

Goal: **Fred will have more opportunities to participate in preferred community activities.**

Objective: **Fred will have an opportunities to participate in a community activity seven days a week by 6/30/2001.**

What happened on this goal this week:

Optional Activity:
Practice Writing An Objective

Your job as a team is to write an objective (or first step) for each of the goals below. **Remember, objectives are the steps needed to move toward a goal.** For this activity, include a time line (for example, By July 5th, Martin will . . .).

Goal: Bill wants to get a job at Taco Bell.

Possible Objective:

Goal: Fernando wants to cook a meal for his girlfriend on her next birthday.

Possible Objective:

Goal: Sylvia wants to learn to swing dance.

Possible Objective: